COTTONWOOD HEIGHTS

RESOLUTION NO. 2009-39

A RESOLUTION APPROVING ENTRY INTO A PROVIDER AGREEMENT WITH TOTAL DENTAL ADMINISTRATORS, INC. FOR DENTAL INSURANCE

WHEREAS, the city council (the "*Council*") of the city of Cottonwood Heights (the "*City*") met in regular session on 23 June 2009 to consider, among other things, approving a provider agreement (the "*Agreement*") with Total Dental Administrators, Inc. ("*TDA*") whereunder TDA would act as the dental insurance provider for the City's employees on the terms and conditions specified in the Agreement; and

WHEREAS, the Council has reviewed the form of the Agreement, a photocopy of which is annexed hereto; and

WHEREAS, after careful consideration, the Council has determined that it is in the best interests of the health, safety and welfare of the citizens of the City to approve the City's entry into the Agreement as proposed;

NOW, THEREFORE, BE IT RESOLVED by the Cottonwood Heights city council that the attached Agreement is hereby approved, and that the City's mayor and recorder are authorized and directed to execute and deliver the Agreement on behalf of the City.

This Resolution, assigned no. 2009-39, shall take effect immediately upon passage.

PASSED AND APPROVED effective 23 June 2009.

COTTONWOOD HEIGHTS CITY COUNCIL

By _____
Kelvyn H. Cullimore, Jr., Mayor

COTTONWOOD HEIGHTS, UTAH
ATTEST: 2005
CORPORATE SEAL

_____
Linda W. Dunlavy, Recorder

VOTING:

Kelvyn H. Cullimore, Jr.	Yea ✓	Nay ___
Gordon M. Thomas	Yea ✓	Nay ___
J. Scott Bracken	Yea ✓	Nay ___
Don J. Antczak	Yea ✓	Nay ___
Bruce T. Jones	Yea ✓	Nay ___

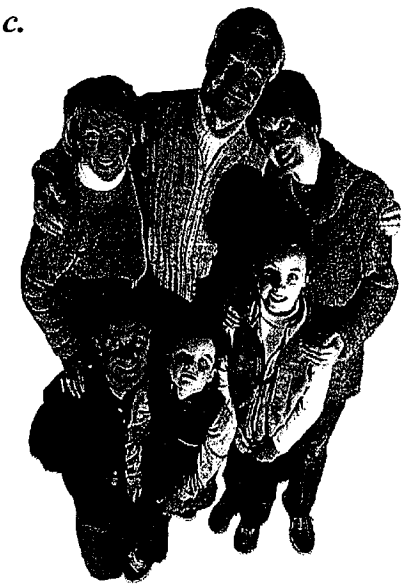
DEPOSITED in the office of the City Recorder this 23rd day of June 2009.

RECORDED this 24 day of June 2009.

WST\CH\524739.1

TDA
Total Dental Administrators, Inc.

Cottonwood Heights City



Welcome to the **TDA-PPO Group Indemnity Dental Plan** underwritten by Companion Life Insurance Company. The **TDA-PPO Dental** Plan offers you the option of receiving your dental care from any dentist you choose (Out-of-Network) or from a Participating Plan Dentist (In-Network); and you don't need to make that decision until you need dental care! However, should you elect to receive your dental care from an In-Network dentist your out of pocket costs will be less.

The following is a brief outline of your dental coverage. For additional information please refer to the employee booklet/certificate you will receive after enrollment or contact TDA.

	(In-Network)	(Out-of-Network)
Class I – Preventive -Oral Examinations (two every twelve months) -Cleanings (once every six months) -X-Rays (bite-wings once every six months) -Pallitave Emergency Treatment	100%	*100%
Class II – Basic Dentistry -Restorations (fillings) -Extractions -Oral Surgery -Endodontics (root canal therapy) -Periodontal Services (treatment of gum tissue)	80%	*80%
Class III – Major Dentistry -Crowns -Dentures -Bridges -Other Prosthetic Services	50%	*50%
Class IV – Orthodontics	50%	*50%
Deductible: No Deductible Oral Exams are Covered at 100% Once Every Six Months		
Maximum Benefit; $1,500 per person per calendar year for all Class I, II & III expenses Lifetime Orthodontic Maximum: $1,500 per child under the age of 19 only.		

Class III Waiting Period: None
Class IV Waiting Period: 12 Months
(Waiting period applies to new enrollees only.)

*Subject to TDA's Allowable MPR Fees
(Maximum Plan Reimbursement)

Total Dental Administrators, Inc.
969 East Murray Holladay Road, Suite 4E
Salt Lake City, Utah 84117
Toll Free: (800) 880-3536 – Local: (801) 268-9740
Fax: (801) 268-9873
Web: www.totaldentaladmin.com
E-mail: customerservice@totaldentaladmin.com

TDA

Total Dental Administrators

Companion Life Insurance Company
P.O. Box 100102 Columbia, SC 29202

Application for Group Dental Coverage

Application is made to Companion Life Insurance Company for a Dental Policy, the provisions of which shall be made available to all eligible classes of Employees.

GENERAL INFORMATION

1. **APPLICATION FOR**
   a. Type of coverage: ☒ PPO-Indemnity ☐ Indemnity ☐ TDA-Companion ☐ ASO ☐ Elite Choice
   b. Requested effective date: 07 / 01 / 2009 (Mo.) (Day) (Year)

2. **EMPLOYER**
   a. Full legal name: Cottonwood Heights City
   b. ☒ Corporation ☐ Proprietorship ☐ Partnership
   c. Contact Person: Angela White
   d. Employer Identification Number (EIN): 202154375
   e. Primary business address in state policy is issued: 1265 E. Fort Union Blvd Ste 250 Cottonwood Heights UT 84047 (Street) (City) (State) (Zip)
   f. Billing address (if different than above): _____ (Street) (City) (State) (Zip)
   g. Telephone Number: (80) 944-7000
   h. Nature of Business: Municipal Govt SIC Code: _____
   i. Affiliates or subsidiaries to be covered (use "Additional Information on page 4 for this if more space is needed):

(Full Legal Name)	(Full Legal Name)
(Street Address)	(Street Address)
(City, State, Zip)	(City, State, Zip)
(Nature of Business)	(Nature of Business)

   j. Number of eligible employees residing outside of the state in which the policy was issued:

(State and number of employees)	(State and number of employees)
(State and number of employees)	(State and number of employees)

3. **OTHER COVERAGE INFORMATION**
   a. Will this coverage supplement other Dental coverage? ☐ Yes ☒ No
      If yes, what other coverage will be provided? _____
   b. Will alternative coverage through a DHMO or other capitation plan be offered? ☐ Yes ☒ No
      If yes, show name of capitation plan. _____
   c. Will this coverage replace a current program? ☒ Yes ☐ No
      If yes, who is the current carrier? PEHP

Return to: **Total Dental Administrators, Inc.**
969 East Murray Holladay Road, Suite 4E Salt Lake City, UT 84117
(801) 268-9873, (800) 880-3536

ELIGIBILITY

1. **CLASSES OF ELIGIBLE EMPLOYEES**

a. Active employees

◆ All active full-time employees (A full-time employee must work 30 hours per week of compensable time.)

◆ Specific class or classes only (Specify class, such as hourly, salaried, covered or not covered by collective bargaining, etc): _____

_____

_____

b. Other - Explain if there are any persons who will be enrolled who are not actively employed: i.e., retirees, COBRA, etc.: _____

_____

2. **NUMBER OF ELIGIBLE EMPLOYEES IN ELIGIBLE CLASSES**

a. Total number of employees on the payroll _____

b. Less number of employees not eligible

1) Temporary or seasonal employees (_____)
2) Employees working less than 30 hours per week (_____)
3) Employees serving probationary period (_____)
4) Employees enrolled in a DMO or Capitation plan (_____)
5) Total ineligible employees (_____)

c. Net eligible employees (a minus b.5) (51)

d. Number of eligible employees who will not be enrolled. Specify Reason: enrollment is optional (_____)

e. Number of eligible employees who will be enrolled. (c minus d) _____

3. **DEPENDENT ELIGIBILITY**

Spouse and/or unmarried children to age 19 or to age 26 if unmarried. If there are any additional eligibility requirements for dependents, please specify:

_____

_____

4. **ENROLLMENT**

To enroll, timely application must be made to Companion Life Insurance Company. Eligible employees must submit a completed application card to the Employer within 30 days following completion of a 0 (0, 30, 60, 90, etc.) day probationary period.

Application for addition of newly acquired eligible dependents through marriage must be submitted to Companion Life Insurance Company, through the Employer, within 30 days of marriage.

Application for continuation of coverage for newborn children of the insured employee and spouse and/or newly acquired adopted children must be submitted within 60 days of the date of birth of the natural child or within 60 days of placement for adoption in the employee's home of a child which is to be adopted.

NOTE: ELIGIBLE employees or their dependents who do not enroll when they first become eligible may make application for enrollment only during the group' annual open enrollment period unless the Employer is contributing 100 percent of the cost of the individual coverage (see "Employer's Contributions" below) and has agreed or is required to make retroactive payment of premium charges.

EMPLOYERS CONRIBUTIONS

1. **PERCENT OR AMOUNT**

The Employer agrees to make the following contribution toward the cost of the employee and dependent coverage:

Employee 70 %
Dependent 70 %

2. **RETROACTIVE COVERAGE**

If the Employer pays 100% of employee and/or dependent coverage, eligible individuals who did not enroll when first eligible will have retroactive coverage from the date of first eligibility upon payment of retroactive premium.

☐ Yes ☐ No

PLAN DESCRIPTION

1. **TERM OF CONTRACT** ☒ One Year ☐ Other (Specify) _____

2. **PLAN OPTIONS:** Choose One ☒ Plan A - Endodontics and Periodontal Services as Class II Benefits
☐ Plan B - Endodontics and Periodontal Services as Class III Benefits
☐ Elite Choice - See Schedule

DEDUCTIBLE:

Per person: ☒ $0 ☐ $25 ☐ $50 ☐ $100 Waived for Class I ☐ Yes ☐ No
Per Family ☒ $0 ☐ $75 ☐ $150 ☐ $300 ☒ NA

MAXIMUM BENEFIT PER YEAR

Per Person ☐ $750 ☐ $1,000 ☐ $1,200 ☒ $1,500 ☐ $2,000
Per Calendar Year for all Covered Dental Benefits - (Class I, II, and Class III)

THE POLICY WILL PAY - "OUT-OF-NETWORK"

Class I: Preventative ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☒ 100% of the Allowable Fee*
Class II: Basic ☐ 50% ☐ 60% ☐ 70% ☒ 80% ☐ 90% ☐ 100% of the Allowable Fee*
Class III: Major ☐ 40% ☒ 50% ☐ 60% ☐ 70% ☐ 80% of the Allowable Fee*

Twelve (12) Month Class III Waiting Period Waived? ☒ Yes ☐ No
Credit given for time covered under this employer's prior Plan? ☐ Yes ☐ No

Class IV: Ortho** ☒ Yes ☐ No ☒ 50% ☐ 60% ☐ 70% ☐ 80% of the Allowable fee

Twelve (12) Month Class IV Waiting Period Waived? ☒ Yes ☐ No
Credit given for time covered under this employer's prior Plan? ☐ Yes ☐ No XNA
Adult Ortho Included? ☐ Yes ☒ No

*Payment is based upon the Allowable Fee
** The Orthodontic Lifetime Maximum (if applicable is): ☐ $750 ☐ $1,000 ☒ $1,500 ☐ $2,000

3. **PPO**

☒ Yes ☐ No Term of contract: ☒ One Year ☐ Other _____

PPO Payment ("In Network") - Class I 100 % Class II 80 % Class III 50 %

PREMIUMS AGREED TO

TDA-PPO/TDA Companion Plans

1A. 2 - Tier ☐ 3 - Tier ☒ 4 - Tier ☐

2 - Tier	3 - Tier	4 - Tier	
Employee	Employee	Employee	45.21 per month
Employee & Dep. (Family)	Employee & 1 Dep.	Employee & Spouse (+1)	57.43 per month
	Employee & 2 + Dep. (Family)	Employee & Child(ren)(+2)	83.53 per month
		Family(Emp. +3 or more)	_____ per month

Elite Choice

1B. 2 - Tier ☐ 3 - Tier ☐ 4 - Tier ☐

2 - Tier	3 - Tier	4 - Tier	
Employee	Employee	Employee	_____ per month
Employee & Dep. (Family)	Employee & 1 Dep.	Employee & Spouse (+1)	_____ per month
	Employee & 2 + Dep. (Family)	Employee & Child(ren)(+2)	_____ per month
		Family(Emp. +3 or more)	_____ per month

2. Initial amount submitted with this Application $ _____
Please attach a copy of the initial Census.

ADDITIONAL INFORMATION

* Oral Exams are Covered at 100% 1 x per 6 months.

SIGNATURE

1. Agreement

a. This application is signed by a person or persons authorized by the Employer to make such an agreement; and
b. The application is received an approved by the Companion Life Insurance Company at its home office; and
c. The initial month's premium is received by Companion Life Insurance Company.

This application will become part of the Group Dental Policy issued to the Employer. Coverage is effective on the first billing due date after the conditions in (a), (b), and (c) above have been met. Coverage is subject to all the terms and conditions of the Group Dental Policy.

2. SIGNATURES

For a corporation, the President or Vice President and the Secretary or Acting Secretary should sign. For a proprietorship, the owner should sign. For a partnership, any partner should sign.

I have read this application, agreed to the terms, and certify that all statements are true and complete. It is understood that provisions of the Group Dental Policy, including premiums therefore, may be amended or changed from time to time, upon written notice from Companion Life Insurance Company to the Employer.

By Cottonwood Heights
(print name)

By: _____
(sign name)

Title Kelvyn H. Cullimore, Jr., Mayor

Date 6/23/09

Witnessed by:

Linda W. Dunlavy, City Recorder
(print agent's name)

By _____
(sign agent's name)

Date 6/23/09